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| Verordnung zur ambulanten Therapie **RehaCity Basel**  Centralbahnstrasse 20  CH-4051 Basel  Telefon +41 (0)61 836 59 10  E-Mail [info@rehacity.ch](mailto:info@rehacity.ch)  www.rehacity.ch | | | | | | | | | | |  | |  | | | | | | | | |
|  | reha-rf_signet_office_swreha-rf_signet_office_swreha-rf_signet_office_swambulante Behandlung | | | | | | | | | |
|  | **Intensive ambulante Rehabilitation** | | | | | | | | | |
|  | **Domizilbehandlung** | | | | | | | | | |
|  |  | | | | | | | | | |
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|  | | | | | | | | | | | | | | | | | | | | | |
| Wir melden folgende Patientin / folgenden Patienten an: | | | | | | | | | | | | | | | | | | | | | |
| Name | | | w m | | | | | | | | | | | Geburtsdatum | | |  | | | | |
| Vorname | | |  | | | | | | | | | | | Telefon-Nr. | | |  | | | | |
| Adresse | | |  | | | | | | | | | | | Versicherer | | |  | | | | |
| PLZ, Ort | | |  | | | | | | | | | | | Vers.- / Unfall-Nr. | | |  | | | | |
|  | Krankheit | | | |  | Unfall | | | | | | | |  | Invalidität | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **Diagnose**  separate Zustellung an Vertrauensarzt gem. KVG | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **Ziel der Behandlung/Bemerkung** | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **Behandlung** | | | | | | | | | | | | | | | | | |  | |  | |
|  | Bitte Rehabilitationsprogramm zusammenstellen | | | | | | | | | | | | | | | | | **Anzahl** | | leer lassen | |
|  | Physiotherapie | | | | | |  | | Lymphdrainage | | | | | | | | |  | |  | |
|  | Med. Trainingstherapie (MTT) | | | | | |  | | Logopädie | | | | | | | | |  | |  | |
|  | Ergotherapie | | | | | |  | | Osteopathie | | | | | | | | |  | |  | |
|  |  | | | | | |  | | Neuropsychologische Therapie | | | | | | | | |  | |  | |
| Der / die Therapeut/in kann mit dem Einverständnis des Arztes / der Ärztin die therapeutischen Massnahmen wechseln, wenn dies zur effizienteren Erreichung des Behandlungszieles beiträgt. | | | | | | | | | | | | | | | | | | | | | |
| Verordnung: | | | | erste zweite  dritte vierte | | | | | | Langzeitverordnung gültig bis: | | | | | | | | |  | | |
| Anzahl Therapien pro Woche: | | | | | | | | |  | | |
| 2 Therapiesitzungen pro Tag | | | | | | | | |  | | |
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|  | **Fachärztliche Konsultation in**  **der Reha Rheinfelden erwünscht** | | | | | | | **Zuweiser**:  ZSR-Nr.  PLZ / Ort  Telefon / Fax  E-Mail  Unterschrift / Stempel | | | | | | | |  | | | | | |
|  |  | vor der Therapieserie | | | | | |
|  |  | nach der Therapieserie | | | | | |
| Datum: | | | | | | | |

